Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: PINE CREEK MEDICAL CENTER 9032 HARRY HINES BLVD DALLAS TX 75235	MFDR Tracking #: M4-10-3715-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: OLD REPUBLIC INSURANCE CO Box #: 42	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fees should be paid in accordance with TDI-DWC §134.403.Hospital Facility Fee Guideline – Outpatient. Carrier failed to reimburse claim in accordance with Medicare bilateral procedure guidelines which states that bilateral procedures are to be paid @ 150% of the fee schedule… Carrier failed to notify HCP of any contractual agreement, therefore, we request that this claim be paid in accordance with TDI-DWC Medical Fee Guidelines."

Amount in Dispute: $923.37

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Response to the request for medical fee dispute resolution was not submitted.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
06/05/2009	Hospital Outpatient Services	$865.31 x 200% = $1,730.62 - $717.00 (carrier payment)	$923.37	$923.37
			Total Due:	$923.37

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on April 26, 2010.

According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Tex. Lab. Code Ann. §413.011(d-3) states that the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On October 28, 2010 the division requested a copy of the contract between the network and the health care provider. The carrier failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed in accordance with §134.403.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 799 – Allowance has been adjusted in accordance wit OPPS multiple procedure rule.
   - 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
   - W3 – Additonal payment made on appeal/reconsideration.
   - W5 – Request of recoupment for an overpayment made to health care provider.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 285 – Please refer to the note above for a detailed explanation of the reduction.
   - 288 – The charge for this procedure exceeds the state mandated fee schedule allowance. Charges have been adjusted to the schedule allowance.
   - 1237 – The PPO reduction is based on a contract held with First Health Institutional PPO Network and your facility.
2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was NOT requested by the requestor.

6. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.403(f)(1)(A) as follows:

APC	Outlier Amount	Separate reimbursement for implantables WAS NOT requested under Rule §134.403	APC + Outlier Amount X 130% or 200%	Fee Schedule (CMS x DWC conversion factor)	Less amount paid by Respondent	Additional amount due Requestor
$865.31	$0.00	$0.00	$0.00	$0.00	$717.00	$923.37

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031©, the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $923.37.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $923.37 plus accrued interest per Division rule at 28 TAC §134.130 and §413.019 (if applicable), due within 30 days of receipt of this order.

DECISION/ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	March 14, 2011 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.